

		FOR OHF USE					

LL 1

**2001**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF PUBLIC AID**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2001)**

IMPORTANT NOTICE  
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION  
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY  
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE  
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE  
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL  
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM  
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<b>I. IDPH Facility ID Number:</b> <u>0018143</u>		<b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b>	
<b>Facility Name:</b> <u>Fair Havens Christian Home</u>		<b>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>July 1, 2000</u> to <u>June 30, 2001</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</b>	
<b>Address:</b> <u>1790 South Fairview Avenue</u> <u>Decatur</u> <u>62521</u> Number City Zip Code		<b>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</b>	
<b>County:</b> <u>Macon</u>		<b>Officer or Administrator of Provider</b> (Signed) _____ (Date) _____	
<b>Telephone Number:</b> <u>217-429-2551</u> <b>Fax #</b> ( ) _____		(Type or Print Name) <u>Mark Havrilka</u>	
<b>IDPA ID Number:</b> <u>23-7437316001</u>		(Title) <u>Chief Financial Office</u>	
<b>Date of Initial License for Current Owners:</b> <u>1975</u>		<b>Paid Preparer</b> (Signed) _____ (Date) _____	
<b>Type of Ownership:</b>		(Print Name and Title) <u>William O. Buskirk</u> <u>CPA</u>	
<input checked="" type="checkbox"/> <b>VOLUNTARY, NON-PROFIT</b>		(Firm Name & Address) <u>Eck, Schafer &amp; Punke, LLP</u> <u>600 East Adams Springfield, IL 62701-1624</u>	
<input checked="" type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust		(Telephone) <u>217-525-1111</u> <b>Fax #</b> <u>217-525-1120</u>	
<b>IRS Exemption Code</b> <u>501(C)3</u>		<b>MAIL TO: OFFICE OF HEALTH FINANCE</b> <b>ILLINOIS DEPARTMENT OF PUBLIC AID</b> <b>201 S. Grand Avenue East</b> <b>Springfield, IL 62763-0001</b> <b>Phone # (217) 782-1630</b>	
<input type="checkbox"/> <b>PROPRIETARY</b>			
<input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____			
<input type="checkbox"/> <b>GOVERNMENTAL</b>			
<input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____			
<b>In the event there are further questions about this report, please contact:</b> <b>Name:</b> <u>William O. Buskirk</u> <b>Telephone Number:</b> <u>217-525-1111</u>			

## STATE OF ILLINOIS

Page 2

Facility Name & ID Number Fair Havens Christian Home# 0018143 Report Period Beginning: July 1, 2000 Ending: June 30, 2001

## III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,  
(must agree with license). Date of change in licensed bedsN/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>161</u>	Skilled (SNF)	<u>161</u>	<u>58,765</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>161</u>	TOTALS	<u>161</u>	<u>58,765</u>	7

## B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>22,596</u>	<u>16,790</u>	<u>507</u>	<u>39,893</u>	8
9	SNF/PED					9
10	ICF	<u>7,983</u>	<u>7,233</u>		<u>15,216</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>30,579</u>	<u>24,023</u>	<u>507</u>	<u>55,109</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed  
bed days on line 7, column 4.) 93.78%

D. How many bed-hold days during this year were paid by Public Aid?

285 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.  
(E.g., day care, "meals on wheels", outpatient therapy)None

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or  
investments not directly related to patient care?YES ☒ NO ☐

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☒ NO ☐

I. On what date did you start providing long term care at this location?

Date started 12/12/1975

J. Was the facility purchased or leased after January 1, 1978?

YES ☐ Date \_\_\_\_\_ NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number  
of beds certified 5 and days of care provided 1,610Medicare Intermediary Mutual of Omaha

## IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED  
CASH\* ☐ CASH\* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 06/30/01 Fiscal Year: 06/30/01

\* All facilities other than governmental must report on the accrual basis.

## STATE OF ILLINOIS

Page 3

Facility Name &amp; ID Number

Fair Havens Christian Home

# 0018143

Report Period Beginning: July 1, 2000

Ending: June 30, 2001

**V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	224,014	28,709	23,860	276,583		276,583		276,583		1
2	Food Purchase		299,374		299,374		299,374	(1,161)	298,213		2
3	Housekeeping	182,185	25,912	8,144	216,241		216,241		216,241		3
4	Laundry	52,185	16,772	2,333	71,290		71,290		71,290		4
5	Heat and Other Utilities			145,044	145,044		145,044	(350)	144,694		5
6	Maintenance	63,479	21,217	42,815	127,511		127,511	10,412	137,923		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	521,863	391,984	222,196	1,136,043		1,136,043	8,901	1,144,944		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			12,600	12,600		12,600		12,600		9
10	Nursing and Medical Records	1,915,382	77,941	85,919	2,079,242		2,079,242		2,079,242		10
10a	Therapy			20,422	20,422		20,422		20,422		10a
11	Activities	28,735		10,652	39,387		39,387		39,387		11
12	Social Services	118,425	5,418	5,294	129,137		129,137		129,137		12
13	Nurse Aide Training										13
14	Program Transportation		25		25		25		25		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	2,062,542	83,384	134,887	2,280,813		2,280,813		2,280,813		16
	<b>C. General Administration</b>										
17	Administrative	85,146	3,101	226,734	314,981		314,981	(173,146)	141,835		17
18	Directors Fees										18
19	Professional Services			4,067	4,067		4,067	15,511	19,578		19
20	Dues, Fees, Subscriptions & Promotions			18,213	18,213		18,213	761	18,974		20
21	Clerical & General Office Expenses	65,735	6,867	40,364	112,966		112,966	23,844	136,810		21
22	Employee Benefits & Payroll Taxes			416,766	416,766		416,766	6,635	423,401		22
23	Inservice Training & Education										23
24	Travel and Seminar			8,188	8,188		8,188	4,350	12,538		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			18,003	18,003		18,003	1,826	19,829		26
27	Other (specify):*							6,946	6,946		27
28	<b>TOTAL General Administration</b>	150,881	9,968	732,335	893,184		893,184	(113,273)	779,911		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,735,286	485,336	1,089,418	4,310,040		4,310,040	(104,372)	4,205,668		29

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

## STATE OF ILLINOIS

Page 4

Facility Name &amp; ID Number

Fair Havens Christian Home

#0018143

Report Period Beginning:

July 1, 2000

Ending:

June 30, 2001

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			207,555	207,555		207,555	22,797	230,352			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			63,211	63,211		63,211	(32,852)	30,359			32
33	Real Estate Taxes			559	559		559	(280)	279			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			271,325	271,325		271,325	(10,335)	260,990			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			1,580	1,580		1,580		1,580			39
40	Barber and Beauty Shops	19,231	1,230	860	21,321		21,321		21,321			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			88,147	88,147		88,147		88,147			42
43	Other (specify):* Apt & Cong			429,838	429,838		429,838	(32,807)	397,031			43
44	<b>TOTAL Special Cost Centers</b>	19,231	1,230	520,425	540,886		540,886	(32,807)	508,079			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,754,517	486,566	1,881,168	5,122,251		5,122,251	(147,514)	4,974,737			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

## STATE OF ILLINOIS

Page 5

Facility Name &amp; ID Number Fair Havens Christian Home

# 0018143

Report Period Beginning:

July 1, 2000

Ending:

June 30, 2001

## VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,161)	2		4
5	Telephone, TV & Radio in Resident Rooms	(1,060)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	22,797	30		9
10	Interest and Other Investment Income	(32,852)	32		10
11	Discounts, Allowances, Rebates & Refunds	(3,020)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest	(32,807)	43		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(280)	33		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(6,477)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (54,860)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)	(92,654)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (92,654)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B) )	\$ (147,514)		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Fair Havens Christian Home

ID# 0018143

Report Period Beginning: July 1, 2000

Ending: June 30, 2001

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
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30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

## STATE OF ILLINOIS

## Summary A

Facility Name &amp; ID Number Fair Havens Christian Home

# 0018143

Report Period Beginning:

July 1, 2000

Ending:

June 30, 2001

## SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,161)	0	0	0	0	0	0	0	0	0	0	(1,161)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(1,060)	710	0	0	0	0	0	0	0	0	0	(350)	5
6	Maintenance	0	10,412	0	0	0	0	0	0	0	0	0	10,412	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(2,221)</b>	<b>11,122</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>8,901</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	(173,146)	0	0	0	0	0	0	0	0	0	(173,146)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	15,511	0	0	0	0	0	0	0	0	0	15,511	19
20	Fees, Subscriptions & Promotions	0	761	0	0	0	0	0	0	0	0	0	761	20
21	Clerical & General Office Expenses	(9,497)	33,341	0	0	0	0	0	0	0	0	0	23,844	21
22	Employee Benefits & Payroll Taxes	0	6,635	0	0	0	0	0	0	0	0	0	6,635	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	4,350	0	0	0	0	0	0	0	0	0	4,350	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	1,826	0	0	0	0	0	0	0	0	0	1,826	26
27	Other (specify):*	0	6,946	0	0	0	0	0	0	0	0	0	6,946	27
28	<b>TOTAL General Administration</b>	<b>(9,497)</b>	<b>(103,776)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(113,273)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(11,718)</b>	<b>(92,654)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(104,372)</b>	<b>29</b>



Facility Name &amp; ID Number Fair Havens Christian Home

# 0018143

Report Period Beginning: July 1, 2000 Ending: June 30, 2001

## VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached Schedule						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V	5 Utilities	\$	Christian Homes, Inc	100.00%	\$ 710	\$ 710 1
2	V	6 Maintenance				10,412	10,412 2
3	V	17 Administrative	215,832			42,686	(173,146) 3
4	V	18 Directors					
5	V	19 Professional Services				15,511	15,511 5
6	V	20 Fees, Subscriptions				761	761 6
7	V	21 Clerical				33,341	33,341 7
8	V	22 Employee Benefits	7,096			13,731	6,635 8
9	V	23 Inservice Training					
10	V	24 Travel&Seminar				4,350	4,350 10
11	V	26 Insurance				1,826	1,826 11
12	V	27 Depreciation				6,946	6,946 12
13	V						
14	Total		\$ 222,928			\$ 130,274	\$ * (92,654) 14

\* Total must agree with the amount recorded on line 34 of Schedule VI.

## STATE OF ILLINOIS

Page 7

Facility Name & ID Number Fair Havens Christian Home # 0018143 Report Period Beginning: July 1, 2000 Ending: June 30, 2001

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
1	This workpaper is not applicable					Hours	Percent	Description	Amount		1
2									\$		2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).  
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,  
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Fair Havens Christian Home# 0018143 Report Period Beginning: July 1, 2000Ending: ne 30, 2001

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	<u>This workpaper is not applicable</u>				\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	1993-A General Rev Bond		x	Debt Restructure	\$3,110.63	01/01/93	\$ 420,000	\$ 363,300	01/01/18	0.0750	\$ 27,425	1	
2	Reilly Mortgage		x	Building & Equipment	\$16,312.47	08/01/74	2,150,100		05/01/01	0.0775	2,938	2	
3												3	
4												4	
5												5	
	Working Capital												
6	CHI Bond Fund	x		Nursing Home		04/01/00	60,000				41	6	
7	CHI Bond Fund	x		Nursing Home	\$7,198.97	10/01/96	671,629			0.0850	32,807	7	
8												8	
9	TOTAL Facility Related				\$26,622.07		\$ 3,301,729	\$ 363,300			\$ 63,211	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 3,301,729	\$ 363,300			\$ 63,211	15	

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.

(See instructions.)

## IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

### B. Real Estate Taxes

B: Real Estate Taxes		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1.	Real Estate Tax accrual used on 2000 report.	\$			1
2.	Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	N/A		2
3.	Under or (over) accrual (line 2 minus line 1).	\$	#VALUE!		3
4.	Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)	\$			4
5.	Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$			5
6.	Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>	\$			6
7.	Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	#VALUE!		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		1996	8		
		1997	9		
		1998	10		
		1999	11		
		2000	12		
				<b>FOR OHF USE ONLY</b>	
				13	FROM R. E. TAX STATEMENT FOR 2000 \$
				14	PLUS APPEAL COST FROM LINE 5 \$
				15	LESS REFUND FROM LINE 6 \$
				16	AMOUNT TO USE FOR RATE CALCULATION \$

**NOTES:**

1. Please indicate a negative number by use of brackets ( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates    **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Office of Health Finance at (217) 782-1630.

**2000 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Fair Havens Christian Home COUNTY Macon

FACILITY IDPH LICENSE NUMBER 0018143

CONTACT PERSON REGARDING THIS REPORT Brenda Lavin

TELEPHONE (217) 732-9651 FAX #: (217) 732-8686

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>04-12-21-428-011</u>	<u>21-16-2 Mueller's 3rd RSVY</u>	\$ <u>298.08</u>	\$ <u>298.08</u>
2. <u>07-07-15-451-006</u>	<u>Hickory Point Christian Vill. Lot 1</u>	\$ <u>2,604.88</u>	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u><u>2,902.96</u></u>	\$ <u><u>298.08</u></u>

**B. Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? \_\_\_\_\_ YES \_\_\_\_\_ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

**C. Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

## X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:
 56,500

B. General Construction Type:
 Exterior
 Masonry
 Frame
 Steel
 Number of Stories
 1

C. Does the Operating Entity?
 ☒ (a) Own the Facility
 ☐ (b) Rent from a Related Organization.
 ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?
 ☒ (a) Own the Equipment
 ☐ (b) Rent equipment from a Related Organization.
 ☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

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F. Does this cost report reflect any organization or pre-operating costs which are being amortized?
 ☐ YES
 ☐ NO

If so, please complete the following:

1. Total Amount Incurred:
 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:
 4. Dates Incurred:

Nature of Costs:
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

## XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	57,000	1972	\$ 54,638	1
2	Home Office				2
3	TOTALS	57,000		\$ 54,638	3

Facility Name &amp; ID Number Fair Havens Christian Home

# 0018143

Report Period Beginning:

July 1, 2000 Ending: June 30, 2001

**XL OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	155		1977	1977	\$ 2,180,767	\$ 51,312	40	\$ 54,519	\$ 3,207	\$ 1,300,306	4
5					384,841		20	19,242	19,242		5
6	6		1983	1983	109,815	2,745	35	3,138	393	48,038	6
7											7
8	Home Office				55,321	1,807		1,807		24,018	8
	<b>Improvement Type**</b>										
9	Land Improvement			1975			20				9
10	Wall Guards			1979	485		15			485	10
11	Garage			1979	4,167	139	30	139	(0)	3,127	11
12	Drain Pipes			1980			20				12
13	Landscaping			1980			20				13
14	Heat Tapes			1980	2,151		15			2,151	14
15	Parking Lot			1980			15				15
16	Drainage Work			1981			20				16
17	Heating System			1981	14,100		10			14,100	17
18	Wall Coverings			1981	1,277		10			1,277	18
19	Heating Control System			1982	20,503	1,025	20	1,025	0	19,731	19
20	Fence Guard Rail			1982	2,027		10			2,027	20
21	Electric Work			1982	2,133		10			2,133	21
22	Fire Alarm			1982	858	43	20		(43)	803	22
23	New Office			1983	2,700	90	30	90		1,665	23
24	Wallcovering			1983	2,301		10			2,301	24
25	Tiling			1983	615		10			615	25
26	Shrubs			1984			10				26
27	Office Remodel			1984	2,594	86	30	86	0	1,498	27
28	Window Installation			1984	2,083		10			2,083	28
29	Down Spouts			1984	639		10			639	29
30	Floor Covering			1984	550		10			550	30
31	Shrubs & Trees			1984			10				31
32	Roof Work			1984	163,201	4,080	40	4,080	0	74,883	32
33	Electric Door			1984	10,229		10			10,229	33
34	Floor Covering			1985	3,457		10			3,457	34
35	Fire Alarm			1985	1,705	85	20	85	0	1,396	35
36	Windows			1985	3,558		10			3,558	36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	Parking Lot	1985	\$	\$ 656	15	\$ 656		\$		37
38	Roof	1985	29,843		15				29,843	38
39	Skylite (Deleted 06/30/91)	1985								39
40	Door Kick Guards	1985	419		10				419	40
41	Landscaping	1986			10					41
42	Electrical Recepticals	1986	2,419	121	20	121	(0)		1,835	42
43	Landscaping	1986			20					43
44	Landscaping	1986			20					44
45	Wiring	1987	7,530	376	20	377	1		5,419	45
46	Ceiling	1987	300		10				300	46
47	Sidewalk	1987			20					47
48	Rewiring	1987	1,600	80	20	80			1,093	48
49	Carpeting	1988								49
50	Wallpapering	1989	505		5				505	50
51	Signs	1989	1,224		5				1,224	51
52	Landscaping	1989			20					52
53	Soap Dispensers	1989	672		5				672	53
54	Compressor Freezer	1989	810		5				810	54
55	Storage Cabinet	1990	1,100	73	15	73	0		833	55
56	Tempering Valve	1990	3,199	213	15	213	0		2,414	56
57	Landscaping	1990			20					57
58	Remodel Dining Room	1991	4,708	235	20	235	0		2,585	58
59	Install Panic Bars	1991	780	58	10	58			780	59
60	Install Window	1991	988	66	15	66	(0)		677	60
61	Flooring	1991	4,380		5				4,380	61
62	Roof Repair	1991	29,860	1,991	15	1,991	(0)		20,242	62
63	A/C Compressor	1991	1,076		5				1,076	63
64	Touchpads Exit Door	1991	792	79	10	79	0		777	64
65	Stainless Steel Sink	1991	1,630	163	10	163			1,589	65
66	Walkway Canopy	1991	4,412	221	20	221	(0)		2,155	66
67	Showers	1991	3,669	367	10	367	(0)		3,517	67
68	Remodel Office	1992	8,715	436	20	436	(0)		3,960	68
69	Fence	1991			20					69
70	TOTAL (lines 4 thru 69)		\$ 3,082,708	\$ 66,547		\$ 89,347	\$ 22,800	\$	1,608,175	70

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 3,082,708	\$ 66,547		\$ 89,347	\$ 22,800	\$ 1,608,175	1
2	Door Locks & Magnets	1992	2,540	254	10	254		2,244	2
3	Interior Landscaping	1992	3,839	384	10	384	(0)	3,296	3
4	Handrails	1993	12,800	853	15	853	0	7,251	4
5	Wall Cabinets	1993	2,564	171	15	171	(0)	1,425	5
6	Bathroom Remodel	1993	12,341	617	20	617	0	5,039	6
7	Nurses Station Desks	1994	18,588	929	20	929	0	6,890	7
8	Alarm/Auto Door	1994	4,257	426	10	426	(0)	3,088	8
9	Cabinets	1994	1,480	99	15	99	(0)	701	9
10	Seal/Stripe Parking Lot	1994			3				10
11	Carpeting in Office	1993	979		5			979	11
12	Gas Rooftop Piping	1994	4,905	245	20	245	0	1,654	12
13	Heating & A/C Unit	1994	5,565	278	20	278	0	1,877	13
14	Remodel Garage	1995	3,704	370	10	370	0	2,374	14
15	Remodel Nurses Station	1995	15,656	1,566	10	1,566	(0)	9,657	15
16	Thru Wall A/C Unit	1995	3,120	390	8	390		2,405	16
17	Flourescent Light Covers	1995	1,218		5			1,218	17
18	Roof Work	1995	52,000	3,467	15	3,467	(0)	21,091	18
19	Service Sink	1995	1,003	100	10	100	0	617	19
20	Wallcovering Dayroom Station 1	1995	2,573	41	5	41		2,573	20
21	Baseboard Pipe	1995	2,978	97	5	97		2,978	21
22	Thru Wall A/C	1995	3,120	390	8	390		2,275	22
23	Shower Valves	1995	1,807	181	10	181	(0)	1,041	23
24	Resident Room Signs	1995	1,516	77	5	77		1,516	24
25	Utility Room Cabinet	1995	599	40	15	40	(0)	230	25
26	Magnets for Fire Doors	1995	795	40	5	40		795	26
27	Fire Door Closers	1995	1,200	80	5	80		1,200	27
28	Install 2 Deck Faucets	1995	826	56	5	56		826	28
29	Nurse Call System	1995	925	93	10	93	(1)	527	29
30	Install Sprinkler Laundry	1995	557	56	10	56	(0)	317	30
31	Electronic Thermostats	1995	733	47	5	47		733	31
32	Breakers 6/receptacles	1995	883	57	5	57		883	32
33	Remodel Main Lobby	1995	4,569	380	5	380		4,569	33
34	TOTAL (lines 1 thru 33)		\$ 3,252,348	\$ 78,331		\$ 101,130	\$ 22,799	\$ 1,700,444	34

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name &amp; ID Number Fair Havens Christian Home

# 0018143

Report Period Beginning:

July 1, 2000 Ending: June 30, 2001

## XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 3,252,348	\$ 78,331		\$ 101,130	\$ 22,799	\$ 1,700,444	1
2	Remodel Station	1996	12,472	1,249	5	1,249		12,472	2
3	Rooftop Heating/AC Dining Room	1996	11,975	1,198	10	1,198	(1)	6,589	3
4	Floorwork Dayroom	1996	2,247	264	5	264		2,247	4
5	Heating & A/C Station	1996	7,550	755	10	755		4,090	5
6	Floorwork Dining Room	1996	6,974	697	10	697	0	3,775	6
7	Honeywell Receiver	1996							7
8	Water Softener	1996	10,580	1,058	10	1,058		5,466	8
9	Water Heaters	1996	39,422	3,942	10	3,942	0	20,367	9
10	2 Sprinkler Cooler	1996	772	154	5	154	0	719	10
11	Remodel Station	1996	8,261	1,652	5	1,652	0	7,572	11
12	Shelving Linen Closet	1997	540	108	5	108		459	12
13	Gas Piping in Laundry	1997	1,155	116	10	116	(1)	493	13
14	Heating & A/C Rooftop	1997	8,950	895	10	895		3,729	14
15	Floorwork Station 4 Hall	1997	10,153	1,015	10	1,015	0	4,145	15
16	Dining Room Announcement	1997	549	110	5	110	(0)	449	16
17	Above Ground Diesel Tank	1992			20				17
18	Replace Concrete Entrance	1995			10				18
19	Replace Concrete Walk	1995			10				19
20	Remodel Beauty Shop	1997	1,370	274	5	274		1,248	20
21	Energy Management System	1997	14,637	732	20	732	(0)	2,684	21
22	Remove Slab Freezer Area	1997	2,860	398	3	398		2,860	22
23	Floor Tile - Station 4 Rooms	1998	7,500	1,500	5	1,500		5,000	23
24	Station 3 Carrier FR A/C	1998	7,597	760	10	760	(0)	2,343	24
25	Carpet Chapel/Lobby/Office	1998	2,483	497	5	497	(0)	1,530	25
26	Wood Cove BS/60 Rooms	1998	9,412	1,882	5	1,882	0	5,803	26
27	Alarm System	1998	11,937	1,194	10	1,194	(0)	3,676	27
28	Wallpaper Station 1 & 2 Rooms	1998	38,443	7,689	5	7,689	(0)	23,681	28
29	Seal/Stripe Parking Lot	1998			3				29
30	Ventilation - Electric Room	1999	1,875	375	5	375		1,031	30
31	48-Safety Grab Bars	1999	864	173	5	173	(0)	461	31
32	161-Glass/Resident Walls	1999	2,256	226	10	226	(0)	603	32
33	Install Grab Bars	1999	2,401	240	10	240	0	600	33
34	TOTAL (lines 1 thru 33)		\$ 3,477,583	\$ 107,484		\$ 130,282	\$ 22,798	\$ 1,824,536	34

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 3,477,583	\$ 107,484		\$ 130,282	\$ 22,798	\$ 1,824,536	1
2	Install 24V Door Closer	1999	1,189	238	5	238	(0)	595	2
3	Water Heater - Station 3	1999	655	131	5	131		295	3
4	Remodel Station 4	1999	26,585	1,772	15	1,772	0	3,979	4
5	Back Door Alarm Pad	1999	2,874	287	10	287	0	646	5
6	Nurse Call Units	1999	598	60	10	60	(0)	130	6
7	Front Countertop	1999	881	59	15	59	(0)	128	7
8	Mixing Valve/Install	1999	524	105	5	105	(0)	219	8
9	Pella Storm Window - 13	1999	527	105	5	105	0	219	9
10	Smoke Detectors-4	1999	553	55	10	55	0	115	10
11	Carrier Rooftop Unit	1999	6,779	678	10	678	(0)	1,412	11
12	Wallpaper Station 3 Rooms	1999	23,706	4,741	5	4,741	0	9,866	12
13	Compressors (3)	2000	2,239	746	3	746	0	1,430	13
14	Cove Base-Station 3	2000	1,408	282	5	282	(0)	517	14
15	Baseboard	2000	1,371	274	5	274	0	480	15
16	Light Fixtures (2 Day Room)	2000	947	95	10	95	(0)	166	16
17	Floor Tile-Hall/Bath/Kitchen	2000	3,079	616	5	616	(0)	1,027	17
18	Panic	2000	1,059	212	5	212	(0)	300	18
19	Security Locks-Front Door	2000	900	180	5	180		225	19
20	Exhaust Fans (6)	2000	702	140	5	140	0	175	20
21	Carrier Rooftop Unit	2000	7,637	764	10	764	(0)	891	21
22	Ceiling Grid Covers	2000	1,418	177	8	177	0	192	22
23	Compressor Room 101	2000	1,131	75	15	75	0	81	23
24	8 x 12 Storage Shed	2000			10				24
25	REMODELING FHCH	2000	6,395	587	10	586	(1)	587	25
26	REMODELING PROJECT	2000	7,075	413	10	413	(0)	413	26
27	(2) BOILERS INSTALLED W/ EMERG LIGHTS	2001	20,942	175	10	175	(0)	175	27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,598,757	\$ 120,451		\$ 143,248	\$ 22,797	\$ 1,848,799	34

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)									
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.									
1	2	3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 3,598,757	\$ 120,451		\$ 143,248	\$ 22,797	\$ 1,848,799	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,598,757	\$ 120,451		\$ 143,248	\$ 22,797	\$ 1,848,799	34

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 519,536	\$ 61,009	\$ 61,009	\$	Various	\$ 682,807	71
72	Current Year Purchases	143,745	18,863	18,863		Various	18,863	72
73	Fully Depreciated Assets	394,303						73
74	Home Office	48,287	4,984	4,984			39,262	74
75	TOTALS	\$ 1,105,871	\$ 84,856	\$ 84,856	\$		\$ 740,932	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Transportation	1986 Wayne Bus	1987	\$ 30,743	\$	\$	\$	8	\$ 30,743	76
77	Patient Transportation	Van	1988	3,317				3	3,317	77
78	Home Office			10,515	2,248	2,248			3,241	78
79										79
80	TOTALS			\$ 44,575	\$ 2,248	\$ 2,248	\$		\$ 37,301	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 4,803,841	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 207,555	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 230,352	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 22,797	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,627,032	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Land/Land Improvements	\$ 1,157,749	\$ 50,988	\$ 245,429	86
87	Duplex/Equipment	6,702,383	221,383	920,589	87
88	Forysth Land Dev. & Assist Living	316,714			88
89	OBLD	12,989	248	3,980	89
90					90
91	TOTALS	\$ 8,189,835	\$ 272,619	\$ 1,169,998	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

## XII. RENTAL COSTS

### A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: This Workpaper is not applicable

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized  
by the length of the lease                     .

9. Option to Buy: ☐ YES ☐ NO Terms:                                     \*

### B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☐ YES ☐ NO

16. Rental Amount for movable equipment: \$                      Description:                                     

(Attach a schedule detailing the breakdown of movable equipment)

### C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning                     

Ending                     

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12.                     /2002 \$                     

13.                     /2003 \$                     

14.                     /2004 \$                     

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

**A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)**

<b>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</b>  <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	<b>2. CLASSROOM PORTION:</b>  IN-HOUSE PROGRAM <input type="checkbox"/>  IN OTHER FACILITY <input type="checkbox"/>  COMMUNITY COLLEGE <input type="checkbox"/>  HOURS PER AIDE _____	<b>3. CLINICAL PORTION:</b>  IN-HOUSE PROGRAM <input type="checkbox"/>  IN OTHER FACILITY <input type="checkbox"/>  HOURS PER AIDE _____
---	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		1		2		3	4
		Facility					
		Drop-outs	Completed	Contract	Total		
1	Community College Tuition	\$	\$	\$	\$		
2	Books and Supplies						
3	Classroom Wages (a)						
4	Clinical Wages (b)						
5	In-House Trainer Wages (c)						
6	Transportation						
7	Contractual Payments						
8	Nurse Aide Competency Tests						
9	TOTALS	\$	\$	\$	\$		
10	SUM OF line 9, col. 1 and 2 (e)	\$					

**C. CONTRACTUAL INCOME**

In the box below record the amount of income your facility received training aides from other facilities.

\$ \_\_\_\_\_

**D. NUMBER OF AIDES TRAINED**

<b>COMPLETED</b>	
1. From this facility	
2. From other facilities (f)	
<b>DROP-OUTS</b>	
1. From this facility	
2. From other facilities (f)	
<b>TOTAL TRAINED</b>	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.  
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.  
 (c) For in-house training programs only. Do not include fringe benefits.  
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.  
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
10	Academic Education		hrs							11
11	Exceptional Care Program									12
12	Other (specify):									13
13										
14	TOTAL			\$		\$	\$		\$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 498,500	\$	1
2	Cash-Patient Deposits	16,570		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	371,199		3
4	Supply Inventory (priced at FIFO )	35,150		4
5	Short-Term Investments	474,039		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Accrued Int &amp; Misc Receivable</u>	1,591		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,397,049	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	414,453		13
14	Buildings, at Historical Cost	9,965,021		14
15	Leasehold Improvements, at Historical Cost	743,293		15
16	Equipment, at Historical Cost	1,385,422		16
17	Accumulated Depreciation (book methods)	(3,730,510)		17
18	Deferred Charges	17,548		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	782,392		21
22	Other Long-Term Assets (spe CIP )	316,714		22
23	Other(specify): <u>Other Assets</u>	5,034		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 9,899,367	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 11,296,416	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 43,795	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	16,570		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	204,361		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	2,903		32
33	Accrued Interest Payable			33
34	Deferred Compensation	1,077,547		34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36				36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,345,176	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	363,300		41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<u>Apt/Congregate Life Right</u>	4,073,797		43
44	<u>Security Deposit</u>	1,080		44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 4,438,177	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 5,783,353	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 5,513,063	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 11,296,416	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	<b>\$ 5,115,185</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	<b>\$ 5,115,185</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>397,878</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	<b>\$ 397,878</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	<b>\$</b>	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	<b>\$ 5,513,063</b>	<b>24 *</b>

\* This must agree with page 17, line 47.

**VII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.  
**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

	Revenue	Amount	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 6,019,026	1
2	Discounts and Allowances for all Levels	(1,037,503)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 4,981,523	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	6,326	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 6,326	8
	<b>C. Other Operating Revenue</b>		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	719	12
13	Barber and Beauty Care	25,569	13
14	Non-Patient Meals	1,161	14
15	Telephone, Television and Radio	1,060	15
16	Rental of Facility Space	2,250	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	1,764	19
20	Radiology and X-Ray	674	20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 33,197	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions	37,329	24
25	Interest and Other Investment Income***	70,006	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 107,335	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>Unrealized Gain/Loss on sale of Equip &amp; Investments</b>	2,128	28
28a	<b>Residential/Congregate</b>	389,620	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 391,748	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 5,520,129	30

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	1,136,043	31
32	Health Care	2,280,813	32
33	General Administration	893,184	33
	<b>B. Capital Expense</b>		
34	Ownership	271,325	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	452,739	35
36	Provider Participation Fee	88,147	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 5,122,251	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	397,878	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 397,878	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? \_\_\_\_\_ If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

## STATE OF ILLINOIS

Page 20

Facility Name &amp; ID Number Fair Havens Christian Home

# 0018143

Report Period Beginning: July 1, 2000

Ending:

June 30, 2001

## XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,708	1,708	\$ 39,442	\$ 23.09	1
2	Assistant Director of Nursing	1,793	1,793	38,559	21.51	2
3	Registered Nurses	15,589	17,065	424,933	24.90	3
4	Licensed Practical Nurses	24,438	26,581	353,522	13.30	4
5	Nurse Aides & Orderlies	112,304	123,335	1,001,182	8.12	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,743	3,743	35,926	9.60	8
9	Activity Director	2,615	2,791	28,734	10.30	9
10	Activity Assistants					10
11	Social Service Workers	10,675	11,395	118,425	10.39	11
12	Dietician					12
13	Food Service Supervisor	1,560	1,685	15,928	9.45	13
14	Head Cook					14
15	Cook Helpers/Assistants	25,601	27,657	208,086	7.52	15
16	Dishwashers					16
17	Maintenance Workers	7,681	8,109	63,479	7.83	17
18	Housekeepers	19,362	21,179	182,185	8.60	18
19	Laundry	6,079	6,808	52,185	7.67	19
20	Administrator	3,585	3,808	85,146	22.36	20
21	Assistant Administrator					21
22	Other Administrative	3,703	3,932	37,933	9.65	22
23	Office Manager	1,686	1,790	27,802	15.53	23
24	Clerical	2,557	2,557	21,819	8.53	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Beauty Shop	2,069	2,200	19,231	8.74	33
34	TOTAL (lines 1 - 33)	246,748	268,136	\$ 2,754,517 *	\$ 10.27	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

## B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	324	\$ 13,846	1.3	35
36	Medical Director	0	12,000	9.3	36
37	Medical Records Consultant	0	600	9.3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	0	822	10.3	39
40	Physical Therapy Consultant	181	8,892	10a.3	40
41	Occupational Therapy Consultant	92	6,726	10a.3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	25	1,838	10a.3	43
44	Activity Consultant				44
45	Social Service Consultant	118	8,909	11.3	45
46	Other(specify) Dental Consultant Fee	10	500	10.3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	750	\$ 54,133		49

## C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

## **XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				Ownership		D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	%	Amount	Description		Amount	Description	Amount		
Nancy Jones	Administrator	0	\$ 30,772	Workers' Compensation Insurance		\$ 87,276	IDPH License Fee	\$		
Blair Wagner	Asst. Administrator	0	54,374	Unemployment Compensation Insurance		9,000	Advertising: Employee Recruitment	1,664		
				FICA Taxes		216,398	Health Care Worker Background Check (Indicate # of checks performed _____)			
				Employee Health Insurance		83,400	Sub Fees & Misc. Fees	2,264		
				Employee Meals			Media, Remote, Aol fees	433		
				Illinois Municipal Retirement Fund (IMRF)*			Misc Dues & Fees	11,299		
				Employee Expense		20,906	Maintenance Fee	2,553		
				Employee Physicals		6,455				
				Employee Uniforms		526	HO Allocation	761		
				Less Apt & Congregate		(8,338)	Less: Public Relations Expense	(		
				Workers Comp Medical Expense		663	Non-allowable advertising	(		
				Unemployment Contribution		481	Yellow page advertising	(		
				HO Allocation		6,635				
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)				\$	85,146	TOTAL (agree to Schedule V, line 22, col.8)		\$	423,401	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees						
				Description	Line #	Amount				
						\$				

\* Attach copy of IMRF notifications

**\*\*See instructions.**

**XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).  
(See instructions.)**

[illegible]

Facility Name & ID Number Fair Havens Christian Home

STATE OF ILLINOIS

# 0018143

Report Period Beginning: July 1, 2000

Page 23

Ending: June 30, 2001

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN, LPN, NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. Life Services \$2,256.06
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? \_\_\_\_\_
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 10
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 4,059 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 88,147  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? Yes For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? No Indicate the amount. \$ 0
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? 100%  
d. Have vehicle usage logs been maintained? Yes  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?  
g. Does the facility transport residents to and from day training? No  
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? Yes  
Firm Name: Eck, Schafer & Punke, LLP The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. To be supplied when completed.
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A  
Attach invoices and a summary of services for all architect and appraisal fees.